Naturopathic Medicine - Adult Intake Forms

Please take the time to fill out the following form. The following form is designed to provide insight into your personal health. When embarking on a personal health plan, it is important to have a benchmark of where you are, your personal and family history and what your behaviors, concerns, and thoughts are with regards to your health. This will provide a basis for further questions during your visit and helps properly assess your situation. All information is for office use only and will be kept confidential.

GENERAL INFORMATION

Full name: ____ Date: ____

Date of birth: ____ Age: ___________________________ Sex: M F

Email Address: ____

Complete Address: ____

City: ____ Postal Code: __________________________________

Tel. No.: Home: ____________________________________ Work: ____

Cell: ____

May we leave a message relating to your visit? Y or N Which number?______________________________________

Occupation: ____ Full-time or Part-time?_____________

Marital Status: single married separated divorced other: ____

Children: yes / no If yes, please list ages: ____

In case of emergency contact: ____

Relationship to patient: _________________________________ Tel. No.____________________________________

How/where did you hear about naturopathic medicine at this clinic? ____

A. PRESENT HEALTH CONCERNS

What are your health concerns in order of importance to you?

1) ____
2) ____
3) ____
4) ____
5) ____

When did you notice any changes in your health?

____
____

Have you been diagnosed with any illnesses? Please explain

____
____

Please list all **current** medications (prescription, over the counter, vitamins, herbs, homeopathy etc.). Include when you started the medication, the name, the brand (if applicable) and the dosage.

____
____
____
____
____
____
____

Please list **past** prescription medications. Include when you started and ended, the name and dosage.

____
____
____

Please list the last physician or health care practitioner seen and when?

____

When was your last blood test, and what was it for?

____

Other health care providers you are seeing? (Name and contact information, if possible)

____
____
____

B. <u>PAST HEALTH CONCERNS</u>

Did you have any health problems at birth? ____
____

Describe your health as a child? ____
____

Describe your health during puberty/teenage years: ____
____

Please list all injuries, surgeries, hospitalizations, accidents or medical procedures that you have had (please include the event, the date and the treatment received):

1. ______
2. ______
3. ______
4. ______
5. ______

List any known current or previous allergies (including food, drugs, herbs, environmental etc.)
______
______

How many times have you been treated with antibiotics? ______

Please indicate what immunizations you have had:

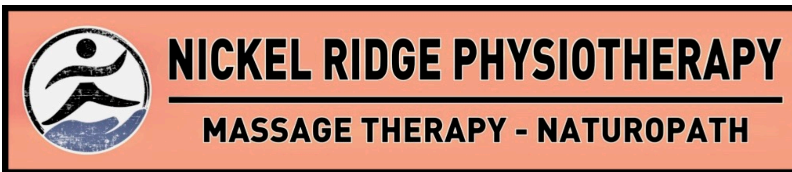
□ DPT (diphtheria, pertussis, tetanus) □ Haemophilus Influenza B
□ Hepatitis A □ Hepatitis B
□ MMR (measles, mumps, rubella) □ "flu"
□ Tetanus booster; ____________when? □ Polio
□Small pox □ HPV

Other:______
Any vaccination reactions: ______

C. FAMILY HEALTH HISTORY

Indicate if anyone in your family has had any of the following health problems:

Health Problem	Relationship to the patient	Age of onset	For how long	Cause of death (if applicable)
Hypertension (Blood Pressure)				
High Cholesterol				
Cancer				
Diabetes				
Asthma				
Allergies				
Heart Problems				
Autoimmune				
Thyroid				
Other				



D. LIFESTYLE INFORMATION

- ❑ use tobacco
- ❑ contact with tobacco smoke
- ❑ use “recreational” drugs
- ❑ Use alcohol
- ❑ use caffeinated beverages
- ❑ wake rested
- ❑ enjoy your work
- ❑ take vacations
- ❑ watch television

What behaviors or habits do you currently engage in that **support** your health?

____

____

What behaviors or habits do you currently engage in that **are destructive** to your health?

____

____

Exercise

How active is your day?____

On average, how many hours of exercise do you do per week? ______________________

Do you belong to a gym? □ YES □ NO If yes, how often do you go per week? ______________

What forms of exercise do you do? (Mind/body, strength training, cardiovascular exercise, flexibility training)? ______

____

Energy

How would you rate your energy on a scale of 0-10 (low to high)? ______________________

Do you experience fatigue? ____

Sleep

How long do you sleep per night? ____

What time do you go to bed? ____

What time do you wake up? ____

Do you wake up in the middle of the night? Y N How often? _______

What is the reason? ____

(Y = YES, N= NO, P= PAST)

Nightmares:	Y N P	Wake Refreshed:	Y N P
Must nap during the day:	Y N P	Sleep walk:	Y N P
Grind teeth:	Y N P	Snore:	Y N P

Stress

On a scale of 1 -10 (low to high) how would you rate the stress in your life? ______________________

What are current sources of stress in your life? ____

____

Please list any major traumas, injuries, stresses or accidents you have experienced in your life?
____
____
____

E. DIETARY INFORMATION

On a scale of 1-10 (low to high) how would you rate your diet? ___________
Is there anything in your diet you would like to change? ___________
How many meals do you eat per day? ___________
Do you follow any specific diet regime (vegetarian, vegan, etc.) ___________
Do you crave certain foods? ___________
Do you avoid certain foods? ___________
How is your appetite? ___________
Are you aware of any differences in how you feel with different foods? ___________
____

Please briefly describe what you consume for:
Breakfast: ___________
Lunch: ___________
Dinner: ___________
Snacks: ___________
Water intake (average): ___________

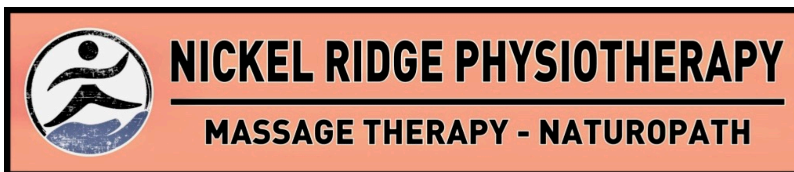
F. REVIEW OF SYSTEMS

Present Weight: ___________ Weight one year ago: ___________ Height: ___________
Maximum weight and when: ___________
Minimum weight as adult & when: ___________ Ideal Weight: ___________

REGARDING THE NEXT SECTION: Circle (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST. Please use the middle column for details.

SKIN

Rash:	Y N P		Color Change:	Y N P
Hives:	Y N P		Lump:	Y N P
Psoriasis:	Y N P		Itchy:	Y N P
Dry:	Y N P		Warts/moles:	Y N P
Cancer:	Y N P		Perspiration:	Y N P
Night sweats:	Y N P		Moistness or oily:	Y N P
Acne:	Y N P		Eczema:	Y N P
Nail Changes:	Y N P		Rosacea:	Y N P



HEAD

Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oily/dry hair (circle which):	Y N P		Hair loss:	Y N P
Dizziness:	Y N P		Frequent sore throat:	Y N P

NOSE

Frequent Colds:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Post Nasal Drip:	Y N P
Polyps:	Y N P		Seasonal Allergies:	Y N P

EYES

Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Cataracts:	Y N P
Glaucoma:	Y N P		Sties:	Y N P
Strain:	Y N P		Discharge:	Y N P
Itchy:	Y N P		Dark under Eyelid:	Y N P
Wear corrective lenses:	Y N P		Dry eyes	Y N P

MOUTH/THROAT

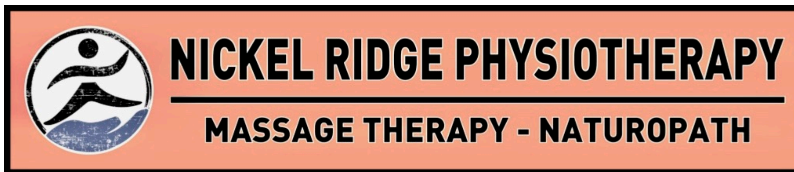
Canker sores:	Y N P		Cold sores:	Y N P
Sore Throat:	Y N P		Gum disease:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Loss of taste:	Y N P		Hoarseness:	Y N P
Bad breathe:	Y N P		Loss of smell:	Y N P

NECK

Stiffness:	Y N P		Swollen Glands:	Y N P
Full movement:	Y N P		Tension:	Y N P

RESPIRATORY

Cough:	Y N P		TB:	Y N P
Shortness of breath with exertion:	Y N P		Bronchitis:	Y N P
Shortness of breath sitting:	Y N P		Pneumonia:	Y N P
Shortness of breath lying down:	Y N P		Asthma:	Y N P
Wheezing:	Y N P		Painful breathing:	Y N P



CARDIOVASCULAR

High Blood Pressure:	Y N P		Rheumatic Fever:	Y N P
Low Blood Pressure	Y N P		Murmurs:	Y N P
Arrhythmias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Chest Pain:	Y N P

URINARY TRACT

Incontinence:	Y N P		Pain with Urination	Y N P
Frequent Infections:	Y N P		Kidney Stones	Y N P
Urgency:	Y N P		Discharge/Blood (circle):	Y N P

GASTROINTESTINAL

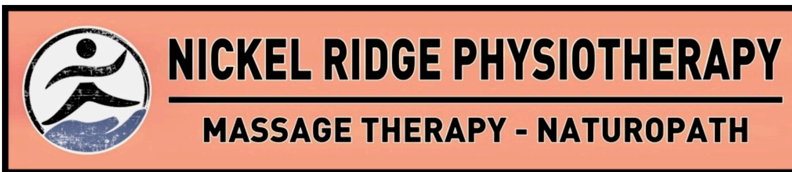
Heartburn:	Y N P		Bowel Movement Freq:	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer	Y N P

MALE REPRODUCTIVE SYSTEM

Testicular pain/swelling:	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.:	Y N P
Discharge:	Y N P		Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P		Sexual Orientation:	
Healthy libido:	Y N P		Other:	

FEMALE REPRODUCTIVE SYSTEM

Age Period Began:			How Often Period Occurs:	
How long period lasts:			Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P		Menstrual Pain:	Y N P
PMS:	Y N P		Food cravings:	Y N P
Times Pregnant:			How many births:	
Miscarriages:			Abortions:	
Last Pap Smear:			Sexual Orientation:	
Any abnormal paps:	Y N P		Age of menopause:	
When was it abnormal:			Use of hormones:	Y N P
Type of hormones used:			Healthy libido:	Y N P



Vaginal dryness	Y N P		Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P		Vaginitis:	Y N P
S.T.D.:	Y N P		Mammography:	Y N P
Bone Density Test:	Y N P		If Yes, what were results:	

MUSCULOSKELETAL

Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P

NERVOUS SYSTEM

Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

MENTAL/EMOTIONAL

Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High-strung/tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating disorder:	Y N P		Psych Hospitalization:	Y N P

G. ENVIRONMENTAL INFORMATION

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ____

____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?

____

Are you particularly sensitive to perfumes, gasoline or other vapors? ______________________________

____

Do you use pesticides, herbicides or other chemicals around your home? ___________________________

____

H. ADDITIONAL INFORMATION

What potential obstacles do you foresee that will prevent you from making healthy lifestyle changes (family, work, etc.)?

____

Why did you choose to come to this clinic? ____

____

What are your expectations from this clinic and our naturopathic doctor? ___________________________

____